MADRAS MEDICAL COLLEGE AND RESEARCH INSTITUTE
CHENNAI

PSYCHOLOGY CASE RECORD

Submitted to

The Tamilnadu Dr. M. G. R. Medical University

In Partial Fulfillment of the Requirements for

DPM Final Examination

April 2011

By

Dr. KAVITHA S.

INSTITUTE OF MENTAL HEALTH, KILPAUK
CHENNAI – 600 010

MADRAS MEDICAL COLLEGE AND RESEARCH INSTITUTE
CHENNAI

PSYCHOLOGY CASE RECORD

Submitted to

The Tamilnadu Dr. M. G. R. Medical University

In Partial Fulfillment of the Requirements for

DPM Final Examination

April 2011

By

Dr. KAVITHA S.

INSTITUTE OF MENTAL HEALTH, KILPAUK
CHENNAI – 600 010

BONAFIDE CERTIFICATE

This is to certify that this is a bonafide record of the work done by **Dr. Kavitha S.** in partial fulfillment of the requirement for the DPM Final Examination of the Tamilnadu Dr. M. G. R. Medical University during the period June 2009 - April 2011.

Assistant Professor of Psychology
and Clinical Psychologist
Institute of Mental Health
Chennai – 600 010

Director
Institute of Mental Health
Chennai – 600 010

Dean
Madras Medical College
Chennai – 600 003

ACKNOWLEDGEMENT

I am very much grateful to the Dean, Madras Medical College, Chennai - 600003, who has given his kind permission to interview the patients for preparing this case record.

I thank the Director, Institute of Mental Health, Chennai - 600 010, who has given his kind permission to interview the patients for preparing this case record.

I am equally grateful to Mr. K. Vijayan, M.A., D.M. & S.P., and Mrs. Smita Ruckmani M.Phil and Ms A G Shanthi, Clinical Psychologists of the Institute of Mental Health, Chennai – 600 010 for the guidance given in the preparation of this case record.

I would also like to thank the patients and their family members who cooperated for undergoing the tests and gave the necessary details required.

INDEX

PATIENT I

Mrs. M

45 years old
Female / Hailing from Urban Back Ground.
Kolathur, Chennai

Un Educated

Currently unemployed

Widow

Hindu by Religion

Tamil speaking

Belonging to LSES

Informant:

1) Daughter - Mrs. Laxmi / 30 yrs / 5th Std / House wife

2) Son - Vadivel / 26 yrs / un educated / salesman in Chappel Company

Information: Inadequate / consistent

Reliability: Fair

Chief Complaints

Being dull and withdrawn
Talking & Laughing to self
Not going for work
Sleep Disturbances
Decreased self care

} For 1½ years

Claiming some imaginary Persons as her husband and as her son
Claiming that she is able to smell Rotten odour from utensils the utensils

} for 10 months

Increased for 3 months

Abusive and assaultive behavior

Gradual onset, continuous, progressive in nature

Not associated with stressor

1st Consultation

History of presenting Illness

Mrs. M. was apparently normal 1½ years back, she was staying in her home, and carrying out her routine work. Her family members noticed that gradually she becomes dull and withdrawn and preoccupied, she started avoiding to interact with family members and in work place.

And also she was found to be talking and laughing to herself. She would sit alone near the tree and would talk to herself. For which if she was questioned she would not reply anything.

Her sleep is disturbed they noticed the frequent awakenings is night, she most of the time, she was found to be talking to herself in the night, she would spend most of the time alone not interacting with others. She stopped going for work. Not showing interest in doing house hold work and not maintaining herself.

She would not show interest in taking care of her husband who was ill for past 2-3 yrs. 2 months later the family members have brought her to magico religious treatment. But the symptoms persisted.

Her husband became very sick and hospitalised. But she did not visit him atleast once, though her husband wished to meet her in the terminal stage of illness. Her children forced her to meet him, but she refused, she didn't give any reason for that.

Her husband Mr. Elumalai died in August 2009. Due to alcoholic liver disease. The day of her husband's death she did not worry about it, she did not show the normal emotional response for the death. She refused to participate in the formalities in the death ceremony. She did not interact with any relatives who visited the ceremony. She was found preoccupied and talking to herself.

16th day of death ceremony she thrown her husband's photo into the well and shouted that person is not her husband.

She started claiming (some imaginary person) as her husband called Mr. Arumugam (Original Husband Mr. Elumalai) also claimed that she has a son called Ravi (Originally she has 3 children).

While talking to herself she would converse as if she is talking to her imaginary husband Mr. Arumugam's to her Imaginary son Mr. Ravi. She also claimed that all her children are born to Arumugam. And also she believed that Mr. Elumalai is still alive. She states that Elumalai is that person one who care her children in the past, while she goes to work for which she paid to him.

Herself care is declining. She would not take bath's change the clothes. She was forced to do so.

She started suspecting her daughter and her sister-in-law that they are spilling blood in the utensils, from which she would able to smell a rotten odour, she frequently tells that bad odour is coming from the vessels. Her family members have tried to explain to her that it is not fact. But she would not be convinced.

So she would repeatedly washed her plates & tumblers. Before receiving food & tea would smell the vessels & food. Most of the days she would refuse to take home made food she would eat the food obtained from hotel. She would the same saree daily, she would wash it and wear the same, for which she said that clothes are also foul smelling, the bad odour is the present in her clothes.

She would remain unbathed for days together, she needs assistance to maintain self care. She would become irritable and abusive, used to abuse the family members and neighbours in filthy language and she would pick up quarrels & neighbours for simple reasons, she would throw stones at others get would get down into the street and would call neighbours for quarrels.

When she was questioned about it sometimes she would bite others. Her social interaction is much reduced not affectionate towards her grand children. She would scold them sometimes would beat them.

For the past three months all the above said symptoms are increased. She is unmanageable by the family, because of her observe / assaultive behaviour neighbour and relatives adviced them for hospitalization so she was brought to IMH for management.

No H/O thought broad casting / Insertion (or) withdrawal

No H/O elated mood / hyperactivity / Spending sprees

No H/O crying spells / low mood / fatiguability

No H/O Forgetfullness / way finding difficulties

No H/O Head Injury / Loc / ENT Bleeding

No H/O Repetitive thoughts / Compulsive Acts

No H/O seizures

Past H/O:

1) No Similar Episodes in the Past

2) Not a Known DM/ HT/TB/BA/Seizure disorder

3) H/O fall from Stairs 2 yrs back in working spot

Report # Lt fore-arm

Nativity treatment given at Puthur

No H/O head Injury / LOC / ENT Bleeding

Family History

Born to nonconsangnous parents

single child

H/O alcohol dependence in husband

No H/O mental Illness

No H/O missing person

No H/O Seizure

No H/O suicidal death

No H/O DM / HT in the family

} in the family

Personal H/O:

Birth History

Early child hood History

} not known

Middle child hood H/O

Educational H/O – No Formal Education

Late Child hood / – not known

Adolescent H/O

Started working in the age of 13 yrs

In agricultural land along & her parents

Details not known

Attained menarche – Details not known

She got married in 16 yrs

Non Consangnous / arranged marriage to a centering labour

Called Mr. Elumalai

She has 3 children

Marital life in satifactory

Sexual history not elecitable

Occupational H/O

- She had been working as a constructed labour for the part 22 yrs
- She was very regular to work
- Hard working / very responsible

- Discontinued the job 2 years back after accident happened
- Then she was working in a hotel for 6 months as maid
- Currently unemployed

Substance H/O

- She is a chronic snuff user - for the part 20 yrs
- No other substance abuse

Premorbid

1) Sociable
2) Well adjustable
3) Hard working
4) Religious
5) Not very sensitive to criticism
6) Responsible towards family
7) Ambiverted

Menstural H/O

Attained menopause 1 year back

General Examination:

Thin build

Conscious

Oriented

A febrile

Anaemic / not jaundiced / No cyanosis / No clubbing / No pedal edema / No generalized lymphadenopathy / No thyroid gland enlargement –

Mal union (Lt) forearm proximal to wrist

Systemic examination

CVS : S1S2+

RS : NVBS+ BP : 100/60 mmHg

P/A : Soft, no organomegaly Pulse : 82 / per min

CNS : No FND

Mental status examination (on admission 19/06/2010) (General appearance, behaviour, attitude)

- alert, ambulant female, looks appropriate for her age, entered into the room by her own took the seat offered, hair unkempt, dressed carelessly, unclean, foul smelling
- Co-operative
- Rapport established
- gaze contact made / not sustained
- Psycho motor activity is normal
- Speech : Relevent / Coherent
- Rate, tone, quantam – Normal
- Reaction time increased
- Emotion : Mood – euthymic

  Affect – restricted
- Thought : Form normal, stream normal, content : Delusion of misidentification
- Delusion of persecution

Perception

olfactory hallucination

She claims that she is able to smell a rotten odour from the utensils and her clothes.

No auditory / visual hallucination

Higher mental functions

Not done on admission because patient was not cooperative

Mental status examination (On 22.06.2010)

Alert, ambulant, intouch with surrounding, dressed adequately, clean and well kempt, Co-operative, rapport established, gaze contact made not sustained.

Speech – Relevant and Coherent,

Rate , tone, quantam normal

Reaction time increased

Emotion

Mood – euthymic

Affect restricted

Thought - Form normal, stream normal

Content – Delusion of misidentification, delusion of persecution

Perception

Olfactory hallucination present

Higher mental function

Attention - arousable

Concentration – ill sustained

Orientation – Time, place, person, intact

Memory – immediate, Recent, Remote } intact

Intelligence

- Able to do simple calculation

- General funds of information is adequate for her level of education

- unable to deal proverb

- abstraction poor

Judgement

Personal - impaired

Hyphothetical intact

Insight Grade I (absent)

Psychological assessment report

A right handed illeutrate widow was assessed with battery if psychological test for psychopathology and organicity.

During testing co-operation and communication were not consistent, attention could be arosable, but not sustained, talk relevant, and irrelevant, emotional reaction were limited.

Psychopathological test

Brought out evidence of delusions, conceptual disorganization with suspiciousness and hostility suggestive of psychopathology of positive nature with evidence of negative symptoms in the areas of affect, abstraction, and conversation, score on PANSS – positive 23, negative scoring 27.

Projective test

Roshalk test showed

1. Card rejection

2. Disorganisation of personality

3. No popular responses

4. Marked immature responses

Suggestive of possibility of organicity on her.

To conform organicity

1. MMSE

2. Bendard gestalt

3. Bechlor memory scale

4. Bhatia short scale are given

Finding shows

Impairment in the cognitive function in the areas of

1. Registration

2. Visual Motor Function

3. Memory

4. Intelligence

Suggestive of organicity on her

MMSE - 19/30

IQ – 68

Memory quotient – 50

Impression

With this psychometric profile the patient manifested abnormal behavior of psychiatric proportion in the background of organicity due to moderate brain dysfunction.

Diagnostic formulation

45 year female broad with complaints of psychotic illness for the past 1½ years increased for 10 months. 1st consultation for IMH, insidious onset progressive illness with nil significant family history, past psychiatric history without medical illness, physical examination shows anemia, mental status examination reveals difficult rapport, relevant and coherent talk, in thought content reveals delusion of misidentification, delusion of persecution with olfactory hallucination with euthymic mood with restricted affect, HMF shows, in sustained

Investigation

Blood investigation – **WNL** except Hb % reduced

ECG and chest x-ray – normal

Neurologist opinion

No organicity in brain

Final diagnosis

F 20.3 undifferentiated schizophrenia

Treatment

Pharmachological management

T – Respirdone 2 mg 1 0 1

T – Benzhexol 2 mg 1 0 1

T – Nitrazapem 5 mg 0 0 1

Psychotherapy

Family education

Complaince therapy

PATIENT II

Name	:	Mr. T
Age	:	34 yrs
Sex	:	Male
Marital status	:	Unmarried
Occupation	:	employed
Religion	:	Hindu
Education	:	+2
Socio economic	:	MSES
Informants	:	Mother
Information	:	Reliable, Adequate and consistent

REASONS FOR CONSULTATION:

- Suspecting others
- Hearing voices
- Neglect self care — 1 ½ years
- Not going for work
- Sleep disturbance
- Recurrent thoughts of contamination
- Excessive washing of hands — 6 months
- Thoughts being known to others - 1 month

Insidious onset, continuous, progressive, associated with any stressor,

1st consultation at IMH. On treatment for past 1 year

HISTORY OF PRESENT ILLNESS:

Patient was apparently normal about 1½ years back living with his parents working as salesman in a private company and having good interpersonal relationship.Once he had a

fight with people in a neighbourhood house regarding disposal of sewage which resulted in physical assault.The neighbour had threatened that he had political influence and would harm him.From then on the patient started expressing fear that the neighbor would harm him.Next day he and apologized to the neighbour and the issue was resolved by talks and the neighbour also apologized in return.But the patient was not convinced and he started saying that the neighbor was still trying to harm him.He used to tell that the neighbor is making gestures to several people indicating that he should be followed.The patient used to tell that wherever he went he was being followed by people set up by the neighbor to follow him and to report his activities.He started saying that he could hear voices of several unknown males and that of his neighbor discussing among themselves the different ways to harm him.He didn't leave his room claiming that he would harmed and discontinued going to work.Gradually he started to bath and change his clothes less frequently about once in 2 to 3 days.He used to remain preoccupied and at times start shouting that people are coming to harm him and beg his parents to save him from them.He slept only about 4 to 5 hours in a day pacing inside the room or sitting in a place preoccupied.After one year of such behavioural disturbance he was taken to private psychiatrist and treated with tab.Risperidone 2 mg 1-0-2, tab.Benzhexol 2 mg 1-0-1 and tab.Diazepam 5 mg 0-0-2.With treatment his suspiciousness,hearing voices,sleep and self care improved within 6 to 7 months.He discontinued the drugs claiming that he was feeling tired and drowsy always. He didn't go for work.For the past 6 months it was noticed that he was frequently washing his hands and on enquiry the patient explained that he felt when he touched certain articles in bathroom whether he would get the germs present in the objects.Gradually he started to wash his hands for about 10 to 15 minutes everytime he touched any object in the house.He used to spend about 7 to 8 hours in a day involved in washing.For past 1 month he started saying that the neighbor was incorporating the germs in the objects so that he would be affected by life threatening illness.He started saying that the neighbor was coming to know of all his thoughts through by some unknown mechanism and gesturing at him in a mocking way. His sleep and self care also reduced. He was brought to IMH for treatment.

No history of persistent sad mood / crying spells / suicidal ideas.

No history of elated mood / excessive spending / tall claims.

No history of substance abuse.

PAST HISTORY:

No history of any chronic illness / drug allergy / seizures / head injury

FA**MILY HISTORY:**

H/o psychotic illness of long duration in maternal aunt.

H/o alcohol dependence in father.

PERSONAL HISTORY:

Full Term Normal Delivery. Developmental milestones normal.

Studied upto +2, working as salesman in private company for 6 years.

Alcohol use – drinks 90 ml of rum about once in 2 to 3 months with his friends from 21 years of age. Last drink 3 years back.

Unmarried

PREMORBID PERSONALITY:

Liked being alone, aloof, had few friends, adjustable, responsible, religious.

PHYSICAL EXAMINATION:

Moderately built and nourished.

General examination – No abnormality detected.

BP – 130/80 mm Hg.

PR-88/min.

CVS – S1, S2 heard.

RS – NVBS heard.

Abdomen – Soft, nontender, No organomegaly

CNS – Clinically normal.

Bilateral fundus – Normal.

MENTAL STATUS EXAMINATION:

Patient dressed adequately and appropriately entered the interview room accompanied by his mother.Was anxious,restless and frequently asking why he was being questioned.Guarded,Gaze contact made but not maintained.Rapport difficult to establish.

Psychomotor activity was increased.No stereotypy / posturing / gesturing

Talk – relevant and coherent

Quantum normal; rate normal, tone anxious and at times irritable.

Emotions : Mood – dysthymic

Affect – anxious ,at times irritable, appropriate, no lability

Thought – No formal thought disorder, stream normal

Delusions of persecution

Delusions of reference.

Thought broadcasting

Obsession of contamination

Compulsion - washing

Perception – No abnormality

OTHER COGNITIVE FUNCTIONS:

Alert

Attention arousable, concentration ill sustained.

Orientated to time / place / person

Memory – Immediate , Recent and Remote intact.

General fund of information adequate

Arithmatic ability - adequate

Abstract thinking – intact

Judgement - hypothetical situation - Intact.

Personal situation - Intact

Insight – Denies mental illness and need for treatment. Grade I.

INVESTIGATIONS:

Haematological investigations – Within Normal Limits

Blood VDRL – Nonreactive.HIV - nonreactive

ECG – Within Normal Limits

Chest X-ray – Normal.

CT brain – normal study

DIAGNOSIS

F20.0- Schizophrenia ,paranoid subtype.

PSYCHOLOGICAL ASSESSMENT.

Mr.T aged 34 years was referred for psychological assessment. He was evaluated with objective tests, rating scales and projective tests.

Behavioural observation

During psychological assessment he was co operative. Eye contact was maintained. Attention and concentration was adequqte.Talk was relevant and coherent.He could comprehend the instructions.Rapport could be established.

Tests administered –

1. Symptom sign Inventory to assess symptom loading on various diagnostic categories.
2. Sentence Completion Test semi projective test to assess the interpersonal problems, attitudes towards significant others in his life, goals and conflicts.
3. Thematic Apperception Test, a projective test of personality used to assess his interpersonal relationship, goals and conflicts.
4. Brief Psychiatric Rating Scale to rate his psychiatric symptoms
5. Multiphasic Questionnaire to assess his personality.
6. Rorschach a projective test of personality used to assess his personality structure and diagnosis.
7. SAPS for positive symptoms
8. PANSS
9. YBOCS

Test Results:

He had significantly elevated scores on paranoid and schizophrenia symptoms as seen from SSI. Some of the paranoid items scored by him are others gesturing at him, thoughts

being known to others. Some of the schizophrenic items scored are having auditory hallucinations, strange and peculiar experiences, being viewed odd by others, getting peculiar thoughts and feeling that something is unusual in his body.

His stories on Thematic Apperception Test are of average length containing descriptions of the individuals and their dresses. He has projected certain interpersonal frictions and hostile attitudes between the characters. He has also projected too many matters merged in a disorganised manner revealing definite thought disturbance in him. He has bizarre thought process, persecutory idea against a person he named, whom he repeatedly brought out in his themes.

On Rorschach ink blot test he has average productivity with adequate mentation.

On PANSS and SAPS he gets ……..

On YBOCS he scores mild severity related to contamination with germs and washing rituals.

Functioning Level:

On global assessment of functioning test, patient falls under the level of 31-40,

Impression :

Patient with adequate cognitive functions, with evidence of schizophrenia with obsessive compulsive symptoms.

FINAL DIAGNOSIS:

F20.0 Schizophrenia, Paranoid subtype

MANAGEMENT:

PHARMACOLOGICAL:

1. T. Risperidone 2 mg 1 – 0 – 2
2. T. Trihexyphenidyl 2 mg 1 – 0 – 1
3. T. Sodium valproate 200 mg 0– 0– 2

PSYCHO THERAPY :

Psycho education to the family emphasizing the importance of drug compliance

At present he is highly disturbed. So, psychological interventions are not of much help at present. However, Supportive psychotherapy and Occupational therapy is of help to divert his talks and thoughts into useful activities.

PATIENT III

Name	:	Mrs. P
Age	:	43 yrs
Sex	:	Female
Marital status	:	Widow
Religion	:	Hindu
Education	:	Uneducated
Socio economic	:	MSES
Informants	:	Daughter and Son
Information	:	Reliable, Adequate and consistent

REASONS FOR CONSULTATION:

- Excessive talk
- Easy irritability
- Tall claims
- Suspecting others
- Sleep disturbance

} 6 months

2nd episode, acute onset, progressive course, no obvious precipitating factors

1st psychiatric consultation

HISTORY OF PRESENT ILLNESS:

Patient was apparently normal about 6 months back living with her daughter and having good interpersonal relationship. When it was noticed by the informant that the patient was talking excessively than before even with unknown people about various issues like politics, religions and that she had visited several foreign places. When enquired why she was telling lies she would laugh and say that she was simply playing with others. Gradually she started becoming easily irritated and would demand that she wanted several varieties of food to eat and that everyone should watch the TV programs that she wanted to watch.She would demand money about 1,000 to 2,000 rupees daily saying that she wanted to eat in hotels.She slept only for 2 to 3 hours in night and would spend the remaining time in watching TV in

loud volume and sing songs. She started saying that she was the creator of the world and that she can destroy it in a second if she gets angry. She started saying that because of her powers some bad people were trying to kill her and continue with their bad works. As she started to assault others claiming that they were coming to harm her she was brought for treatment about 1 month back and started on T.sodium valproate 200 mg 2-2-2,T.Risperidone 2 mg 1-0-1 and T.Diazepam 5 mg 0-0-2.

With treatment her symptoms has reduced in intensity.

No history of sad mood / crying spells / suicidal ideas / suicidal gestures.

No history of hearing voices / seeing images

No history of thoughts being known to others / being controlled by others

No history of substance use

No history of fever / head injury / seizures

PAST HISTORY:

1st episode occurred when patient was 30 years of age. Had the behavioural disturbance of Excessive talk, tall claims, sleep disturbance, easy irritability, abusive, assaultive and excessive spending. After 3 months of behavioural disturbance was taken to private psychiatrist.Took treatment for about 2 months.Exact details of drugs not available.Discontinued drugs on her own as she attained premorbid level of functioning..

No history of Hypertension / Diabetes Mellitus / chronic disease.

FAMILY HISTORY:

History of mental illness paternal aunt, no history of suicide or missing members in the family.

History of alcohol dependence in patient's father and several paternal and maternal uncles.

PERSONAL HISTORY:

Early childhood history is not available.

Born of nonconsanguinous marriage.

Married at the age of 25 years.

Living with her daughter as her son, her husband had died due to MI 3 years back.

PERSONALITY TRAITS:

Adjustable and Easy going.

Tolerant to criticism, responsible.

Highly religious.

PHYSICAL EXAMINATION:

Thin built, not anemic, not jaundiced, no pedal edema.

Pulse – 68/min

BP – 120/80 mm Hg

CVS – S1, S2 heard.

RS – NVBS heard.

Abdomen – Soft, non tender, No organomegaly

CNS – Clinically normal.

Fundus – normal

MENTAL STATUS EXAMINATION:

General Appearance and Behavior: An alert moderately built lady dressed in saree worn in unkempt way entered the interview room with her relatives, Co operative to an extent,Frequently demanded that she wants to go home to eat, Gaze contact made but not maintained,Rapport established with difficulty.

Psychomotor Activity – increased.

Talk – Quantum,tone,rate increased; Reaction time decreased. Relevant and coherent. No pressure of speech.

Emotions : Mood – euthymic

Affect - irritable

Thought – No formal thought disturbance

Stream increased

Content- Delusion of grandiosity, Delusion of persecution,Well systematized,Patient acting on the delusion

Perception – No perceptual disturbances.

OTHER COGNITIVE FUNCTIONS:

Oriented to time,place,person.

Attention aroused

Concentration Ill sustained

Memory-

Immediate – not co operative

Recent- intact

Rremote- intact.

Intelligence average

Abstract thinking – intact

judgment – hypothetical situation,personal situation impaired.

Insight – Absent.

PROVISIONAL DIAGNOSIS:

Bipolar affective disorder current episode mania with psychotic features

PSYCHOLOGICAL ASSESSMENT:

Mrs. P aged 43 years, widow, reported with her daughter. She was referred for psychological assessment. She was evaluated with objective and projective tests.

Behavioral observation -

She was co operative for testing. Eye contact was maintained. Attention and concentration was adequate. Her talk was relevant but at times talks in English. She becomes irritable at times. She was friendly with the examiner and also found to be guarded. She could comprehend the instructions.

Tests administered -

1. Eysenck Personality Questionnaire was used to assess the different dimensions of her personality
2. Symptom Sign Inventory to assess symptom loading on various diagnostic categories.
3. Multiphasic Questionnaire – to assess her personality.
4. Hamilton Rating Scale for Depression

5. Young Mania Rating Scale was used to rate intensity of various symptoms she was exhibiting.
6. Sentence Completion Test was used to elaborate on her attitude towards family, parents, and her interpersonal relationships.
7. Thematic Apperception Test, a projective test of personality used to assess her interpersonal relationship, goals and conflicts.
8. Rorschach test, a projective test of personality used to assess her personality structure and diagnosis.
9. BPRS

Test findings –

On psychopathological testing she gets significant scores on paranoid.

On BPRS,she has positive findings in the area of grandiosity, hostility, suspiciousness, tension and excitement.

On intelligence testing her IQ is 73. Scatter is present which could be due to her present condition.

Projective test showed she has above average productivity with quick mentation. She has partial touch with surroundings. Rorschach protocol with high animal responses, low F+%, few popular responses, colouring responses and presence of movement responses suggestive of affective symptoms with psychotic features.

Impression-A known case of Bipolar affective disorder on partial remission with minimal amount of psychotic features still persisting.

FINAL DIAGNOSIS:

Bipolar affective disorder current episode mania with psychotic features

MANAGEMENT:

T – Respiridone 2 mg 1 0 1

T – Sodium valproate 200 mg 2 2 2

T – Clonozepam 0.5 mg 0 0 1

T – BHL 2 mg 1 0 0

BEHAVIORAL:

Family counseling to provide awareness to the family members about the guarded prognosis for this patient and the importance of rehabilitation.

Relatives were advised to give an understanding atmosphere to the patient and help him not to get confused.

Importance of proper follow-up is stressed to monitor the condition of patient and to help the family members in dealing with the patient adequately.

PATIENT IV

Name	:	Mr.V
Age	:	18 yrs
Sex	:	Male
Marital status	:	unmarried
Religion	:	Hinduism
Education	:	+2 Fail
Socio economic	:	MSES
Place	:	Hyderabad
Informants	:	Mother, Father
Information	:	Reliable, Adequate and consistent
Reliability	:	Good

REASONS FOR CONSULTATION

- Alcohol consumption
- Unable to concentrate in studies

} 3 years

- Sleep disturbance
- Irritability
- Wandering
- Self injurious behavior
- Excessive cigerrate smoking

} 1 year

- Abusive and aggressive behavior for 6 months

Insidious onset, continuous course, 1st psychiatric consultation

Not Precipitated by a stressor

HISTORY OF PRESENTING ILLNESS:

Mr. V 18 years old by apparently normal 3 years back. He started consuming alcohol introduced by his friends while he failed 10^{th} standard. He started with 150 ml beer and developed tolerance upto 1800 – 2400 ml. He stopped alcohol for 2 months due to headache and vomiting. To overcome these affects he started smoking cigarate excessively.

He had an affair with a girl, he was fully preoccupaid about her, he used to think about her atleast 20 hours in a day. So he could not able to concentrate in his study. He failed in +2. He was troubled by the girls brother, who apposed their love. Each of them fought. Issue was taken to police station. Past one year his parents noticed he has disturbed sleep, he falls in sleep around 2.30 a.m. slept for 4 hours. He was unable to concentrate in his studies. He keeps on think about her parents arguments. He could not go to sleep whole the night. His parents reported that he becomes disobedient not returning home in time. And spends all the time with his friends. He roaming purposeless. If they ask about him. He become irritable and abusing. He has runout from house twice in the past two years. Whenever he was scolded by his parents. He would become irritable and restless and make injurius in his body, like burning his arm, making cutting with sharp instruments.

No H/O head injury/ LOC/ ENT Bleeding

No history of lauging to self / talking to self

No H/O crying spells

No H/O inflated self esteem

No H/O social problem

No H/O debts

Legal complication +

No history of suicidal, ideation are attempt

No H/O of thought insertion / withdrawal and broadcasting

Nil Medical and Psychatric History

Family History

He was born to non consangnous parents.

First sibiling of two children

Father known alcoholic

Grandfather known alcoholic / IV drug abuser

No family history (Psychiatric illness / suicidal death / missing persons / DM/ HT/ BA/TB)

Personal History

Antinatal H/O –	mother suffering from PIH
	No H/O drug intake
Delivery history -	Full term / Normal / at Chengalpet GH
	Cried immediately / weight 3.5 kg
	Immunised / Breastfed
Childhood H/O -	Developmental milestones normal
Education H/O -	Entered school in 3 years to pre KG
	He changed school 3 times in 10 years due to father's transfer
	High school Jain Patrices at Hyderabad, failed in 10^{th} in 2 subjects passed in special exam
	Entered in saithanya Junior College, Hyderabad.
	Failed in +1 in one subject
	Failed in +2 two subjects
Occupational H/O	Nil
Sexual H/O	History of masturbation / Twice weekly / during sleep / no sexual contact / interested in seeing sex movies
Substance H/O	Known smoker for 5 years 20-30 cigarretes perday
Premorbid H/O	Extravert
	School trauency present
	Adament
	Sensitive to criticism
	Destructive behaviour
	Religious
	Less responsible

PHYSICAL EXAMINATION:

Alert , ambulant Self injurious scar over the Right and left forearm

BP – 120/80 mm Hg.

PR-80/min.

CVS – S1, S2 heard.

RS – NVBS heard.

Abdomen – Soft, non tender, No organomegaly

CNS – Clinically normal.

Fundus – normal

MENTAL STATUS EXAMINATION:

General Appearance and Behavior: An alert moderately well built adolescent boy dressed adequately and appropriately entered the interview room, co operative. Rapport was established. Gaze contact made and maintained.

Psychomotor activity – within normal limits

Talk – relevant and coherent. Quantum, rate and tone- normal. Reaction time normal.

Emotions : Mood – confused

Affect – restricted

Thought- Form, stream- normal

Content – delusion of persecution

Ideas of worthlessness

Ideas of hopelessness

No suicidal ideas

Perception – No abnormality

OTHER COGNITIVE FUNCTIONS:

Oriented to time, place and person

Attention aroused, Concentration well sustained

Digit Forward – 5

Digit Backward – 4

Memory – immediate, recent and remote – intact

General fund of information – adequate

Average intelligence

Abstract thinking intact.

Judgement to test situation intact

Insight: Grade V.

DIAGNOSTIC FORMULATION

PROVISIONAL DIAGNOSIS

PSYCHOLOGICAL ASSESSMENT:

Mr.V aged 18 years, adolescent boy came with scholastic backwardness and behavior was assessed with psychological test for psychopathology on assessment. This person showed disproportionate anger with evidence of self injurious behavior and multiple substances abuses in the background of vulnerable personality with inadequate familiar situation. (EPQ – N10, L6, P8, E13)

Cognitive finding were scattering type between verbal and nonverbal intelligence favouring of minimal brain dysfunction. Manifested in the form of specific learning this order and also colouring the personality.

Impression

Specific learning disability

Diagnosis

Mental subnormality, adjustment disorder

Pharmaco therapy

T – Sodium valproate 200 mg 1 0 1

T – BCT 1 0 1

Non pharmacological management

Psycho therapy – 1 to 1

Counseling

Educating the family members

PATIENT V

Name	:	Mr. G
Age	:	40 yrs
Sex	:	Male
Marital status	:	unmarried
Religion	:	Hinduism
Education	:	+2 Std
Socio economic	:	MSES
Place	:	Periyar Nagar, Chennai
Informants	:	Father
Information	:	Reliable, Adequate and consistent
Reliability	:	Good

REASONS FOR CONSULTATION

Mr. G has been brought by his father for transferring her mother's pension to his son's name. Since he has no vocational skills to earn for living.

- Lack of initiative to do his routine for 2 years
- Sleep disturbance for
- Talking to self for } 1½ years

Illness present for past 20 years. Patient is on treatment with T. Aripiprazole 15 mg 001

T. Chlorpramazine 500 mg 001. Since November 2004. From SCARF Foundation. He has on regular treatment

Mr. G was apparently normal 20 years back. He has completed +2 after 4 attempts. He joint typewriting (lower) at the time he was dull and withdrawn. He was laughing to self at times. When question he was evasive. He showed lake of interest in his work. He was very lethargic.

Considering his poor scholastic performance, his parents did not force him to pursue his studies further. He remained at home and spent his time watching TV. He begans to express suspicious ideas that somebody is watching him. Observing his actions. He began to talk to self. His father them took him is a neurologist and was giving him T. Hexidol tds for 2 years on the advise of neurologist. Then he stopped taking medications for the past 15 years.

2 years back he became very dull. He became poorly communicative. He did not interact with other family members. He had to be forced to take bath and to maintain her personal hygient when he is not forced, he would stay the same and would remain unclean 6 months before her father on the advice of one of his friends to him to SCARF foundation. He was receiving the drugs, he involves himself in some work has adequate sleep. He has been brought by his father to IMH to transfer his mother pension to him so that it would help him in future.

No H/O suicidal attempts / crying to self

No H/O seizures

No H/O head injury

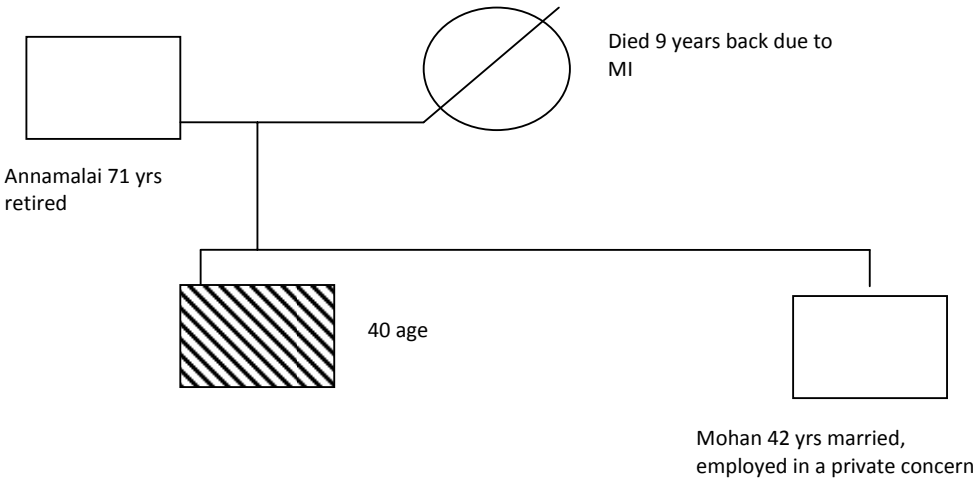
No H/O infection

Past History

No H/O PT/DM/HT

No H/O seizures

Family History



No H/o suicide / seizures / mental illness / absconding / substance abuse

Personal History

- Forcepes delivery, full term
- Developmental mile stones – normal
- Schooling – up to XII std (4 attempted)

  Below average performance at school.

  No H/o lying / stealing / truancy
- Unemployed
- Single
- Used to smoke >1 pocket of cigarette has stopped Smoking for the past four years.
- Living in a rented house, with his father No. of rooms- 2 Pt's role is dependent
- Source of income – Mother's pension.

Premorbid personality

- Regular to school, no temper tantrum
  No bed wetting / no thumb sucking behavior
- Introvert had only few friends
- God fearing

Physical examination

Pt is well built, moderately nourished

Hydration fair

Not anaemic

	CVS- S_1 S_2
BP 110/70	RS : NVBS heard
PR 72/mt	PA : Soft
	CNS : NO FND
	fundus normal

MSE **General appearance and behaviour**

Mr. G is conscious and ambulant. He entered the room on his own and took the seat offered. Rapport established with initial difficulty. Gaze contact made and maintained. No involuntary movements. Has inappropriate smile at times.

PMA – normal

Talk

Quantum, tone rate is high

Reaction time – varied often prolonged

Relevant to personal details

Mood

Subjective – euthymic

objective – blunted affect

Thought

Poverty of content of thought present

No delusion

No suicidal ideas

Perception

No hallucinations

Oriented to time, place and person

Attention and concentration

Attention arousable, concentration well sustained.

DF – 3, DB – 2

Serial subtraction test = 20 – 1 upto 1

Memory

Immediate
Recent } intact

Remote

Intelligence

General fund of information poor

Abstract thinking – impaired

Judgement - impaired

Insight Grade I

Clinical psychologist report

Mr. G aged 46 years. Unmarried reported with his father. He has history of mental illness under regular treatment from outside psychiatrist. He was referred psychological assessments. He was co-operative for testing. Eye contact was maintained. Attention and concentration was inadequate. Talks in low tone, muttering to self and inappropriate laugh was present at times. He could comprehend the instructions.

On intelligence test, his IQ is 56. Scattering present which could be due to his illness. So it has to be interpret cautiously.

On Bender gestalt test, his visual motor perception is mildly in adequate. He could recall three figures out of nine figures presented.

Psychopathological testing, he gets significant scores on schizophrenia. On rating scale, he gets positive findings in the area of emotional withdrawal, conceptual disorganization, hallucinatory behaviour preoccupies suggestive of gross psychopathology on him (BPRS).

Projective test, he has below average productivity in adequate mentation. He is not in touch in reality. Roschack protocol with rejection of card, poor form level, low number of responses, sterotype responses suggestive of schizophrenic illness.

Impression

From the history and psychometry findings patient has schizophrenic illness on gross psychopatholgy with negative symptoms (IQ-56).

Final Diagnosis

Chronic schizophrenia

Investigation

CP

Blood urea sugar

ECH with chest X-ray